Discharge Protocols for Community Services Boards and State Hospitals

Virginia Department of Behavioral Health and Developmental Services

These protocols provide consistent direction and coordination of those activities required of state hospitals and community services boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in applicable provisions of the *Code of Virginia* or the Community Services Performance Contract and Partnership Agreement. This version reflects minor editorial changes in and clarifications of the version dated 01-05-2010.

Discharge Protocols for CSBs and State Hospitals

DEFINITIONS

The following words and terms when used in these protocols shall have the following meanings, unless the content clearly indicates otherwise.

Acute admission or acute care treatment means intensive short term psychiatric treatment in a state hospital for a period of less than 30 days.

Authorized representative means a person permitted by law or regulations to authorize the disclosure of information and give consent to treatment and services, including medical treatment, or participation in human research on behalf of an individual who lacks the mental capacity to make these decisions. An authorized representative may include an attorney-in-fact, health care agent, legal guardian, or, if these are not available, the individual's family member (spouse, adult child, parent, adult brother or sister, or any other relative of the individual) or a next friend of the individual (defined in 12VAC35-115-146).

Community services board (CSB) means the public body established pursuant to § 37.2-501 of the *Code of Virginia* that provides mental health, developmental, (formerly referred to as mental retardation), and substance abuse services within each city and county that established it. The term CSB includes administrative policy CSBs, operating CSBs, and the local government department with policy-advisory CSB. CSB also includes the organization that provides services through its own staff or through contracts with other organizations and providers. In these protocols, CSB also means the behavioral health authority, defined in § 37.2-100 of the *Code of Virginia*, established in Richmond pursuant to § 37.2-602 .

Case management CSB means the public body established pursuant to § 37.2-501 or § 37.2-602 of the *Code of Virginia* that serves the city or county in which an adult, a minor's parent, or an authorized representative resides. The case management CSB is responsible for case management, liaison with the state hospital when an individual is admitted to it, and discharge planning. In these protocols, CSB means case management CSB. Case management CSB designations may vary under the following conditions

When the individual's living situation is unknown or can not be determined, then the case management CSB is the CSB that completed the preadmission screening form.

For individuals who are transient or homeless, the CSB serving the locality in which the individual is living or sheltered at the time of preadmission screening is the case management CSB. However, when a CSB other than the preadmission screening CSB is continuing to provide services and supports to the individual, then the case management CSB is the CSB providing those services and supports.

For individuals in state, regional, or local correctional facilities, local hospitals, Veteran's Administration facilities, or regional treatment or substance abuse detox programs, the case management CSB is the CSB serving the catchment area in which the individual resided prior to incarceration or admission.

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Comprehensive treatment planning meeting means the meeting that follows the initial treatment meeting and occurs within seven days of admission to a state hospital. At this meeting, the individual's comprehensive treatment plan (CTP) is developed by the treatment team in consultation with the individual, his or her authorized representative, the CSB, and, with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct, and support all aspects of the individual's treatment.

Department means the Department of Behavioral Health and Developmental Services.

Discharge plan means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.2-505, § 37.2-837, or § 16.1-346.1 of the *Code of Virginia* in consultation with the individual, his or her authorized representative, and the state hospital treatment team. This plan describes the community services and supports needed by the individual following an episode of hospitalization and identifies the providers that have agreed to provide these services and supports. An individual may not be discharged from a state hospital without the discharge plan.

A completed plan means the *Discharge Plan Form (DBH 1190C)* on which all of the services and supports to be received upon discharge are shown, the providers that have agreed to provide those services and supports are identified, the frequency of those services and supports is noted, and a specific date of discharge is entered.

Dual diagnosis means an individual has been clinically assessed as having a serious mental illness and:

1. co-occurring developmental disability, defined as mental retardation in § 37.2-100 of the *Code of Virginia,* **OR;**
2. a co-occurring substance abuse disorder, as defined in § 37.2-100 of the *Code of Virginia*.

Extended treatment means intermediate or extended treatment in a state hospital for a period of 30 days or more provided to individuals with severe psychiatric impairments, emotional disturbances, or multiple service needs.

Individual means a person receiving services. This term replaces consumer, client, and patient.

Involuntary admission means admission of an adult or minor that is ordered by a court through a civil procedure in accordance with § 37.2-814 et seq. or § 16.1-346.1 of the Code of Virginia.

Minor means an individual who is less then 18 years of age.

Preadmission screening means a face-to-face clinical assessment of an individual performed by a CSB to determine the individual's need for inpatient care and to identify the most appropriate and least restrictive alternative to meet the individual's need.

Primary substance abuse diagnosis means an individual is clinically assessed as having one or more substance abuse or dependence disorders per the current Diagnostic and Statistical Manual of Mental Disorders (DSM); and the individual does not have a Axis I mental health disorder.

Secure site database means the secure, internet web-based application that identifies the case management CSB and state hospital, and contains individual-specific discharge implementation and planning documentation required under these protocols. This documentation includes the Needs Upon Discharge Form, Discharge Plan Form, Safety and Support Plan, Extraordinary Barriers to Discharge Report, and CSB Discharge Planning Notes.

State hospital means a hospital, psychiatric institute, or other institution operated by the Department that provides care and treatment for individuals with mental illness.

Treatment plan mean a written plan that identifies the individual's treatment, training, and service needs and stipulates the goals, objectives, and interventions designed to address those needs. There are two sequential levels of treatment plans:
1. The initial treatment plan that directs the course of care during the first hours and days after admission; and
2. The comprehensive treatment plan (CTP) that is developed by the treatment team with CSB consultation and guides, directs, and supports all treatment of the individual receiving services in the state hospital.

Treatment plan review (TPR) means treatment planning meetings or conferences held subsequent to the CTP meeting.

Treatment team means the group of individuals that is responsible for the care and treatment of the individual during the period of hospitalization in a state hospital. Team members shall include the individual receiving services, a psychiatrist, psychologist, social worker, and nurse. Additional team members may be added by the team leader based on the individual's needs. While not actual members of the treatment team, CSB staff shall actively participate, collaborate, and consult with the treatment team during the individual's hospitalization. The treatment team is responsible for providing all necessary and appropriate supports to assist the CSB in completing and implementing the individual's discharge plan.

1. Admission to State Hospitals

	State Hospital Responsibilities	CSB Responsibilities
1.1		Section 37.2- 500 of the Code of Virginia states a CSB shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services**.** Section 37.2-809 requires a CSB to conduct an evaluation in person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 to determine whether the person meets the criteria for temporary detention. Section 37.2-816 requires a CSB to provide a preadmission screening report that states whether the individual meets the criteria for involuntary admission, needs involuntary inpatient treatment, and there is no less restrictive alternative to inpatient treatment. The report also shall provide recommendations for the individual's placement, care, and treatment.
1.2	Upon admission, if the individual is not able to make the necessary decisions regarding treatment and discharge planning and an authorized representative does not exist, the state hospital director shall appoint one.	
1.3	The treatment team, utilization review department, and, as appropriate, the forensic coordinator, shall assess each individual upon admission and periodically thereafter to determine whether the state hospital is the most appropriate treatment site. These assessments shall be made available to the CSB for purposes of treatment and discharge planning. ***RECOMMENDED PRACTICES FOR INDIVIDUALS WITH DUAL DIAGNOSES OF MENTAL ILLNESS AND DEVELOPMENTAL DISABILITY***: 1. For individuals with a dual diagnosis, the admitting state hospital shall confer with the appropriate training center to	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in assessments to determine whether the state hospital is the most appropriate treatment site. ***RECOMMENDED PRACTICE:*** It should be the CSB's responsibility to notify the state hospital and training center that serves it of any known individual with the dual diagnosis of mental illness and developmental disability who is receiving local inpatient services through a temporary detention order (TDO), civil commitment, or voluntary admission and may require additional treatment in a state facility.

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	determine which facility can best serve the individual's needs. 2. If an adult with a dual diagnosis is sent to a state hospital under a TDO, consultation prior to or participation at the commitment hearing is expected of: a. state hospital staff, b. staff from the training center serving the area in which the individual resides or the hearing is held, and c. the CSB's mental health and developmental services staffs.	
1.4	Staff shall contact the CSB by telephone within 24 hours of admission, or for weekends and holidays on the next business day, to notify the CSB of the new admission. In addition to contact by the social worker, staff shall fax a copy of the admission face sheet, including the name and phone number of the social worker assigned and the name of the admitting ward, to the CSB within one business day of admission. ***NOTES:*** 1. For all forensic admissions, staff shall provide the CSB with a patient information sheet within one business day of admission. Treatment teams are not responsible for completing the *Needs Upon Discharge Form (DBH 1190F)* for any individual admitted and discharged prior to the CTP. However, the treatment team is responsible for completing the *Discharge Information and Instructions Form.* 3. When reporting admissions to CSBs, staff shall identify those individuals admitted with a primary diagnosis of substance abuse within one business day of admission.	Upon notification of admission, CSB staff shall begin the discharge planning process. If the CSB disputes case management responsibility for the individual, the CSB shall notify the state hospital social worker immediately upon notification of admission. ***NOTES:*** 1. CSBs staff is not responsible for completing the discharge planning forms for individuals admitted to a state hospital who are discharged prior to the CTP. However, CSB responsibilities after discharge will be reflected in the *Discharge Information and Instructions Form (DBH 226)*. (Please see Attachment 3) 2. For all forensic admissions, the CSB shall participate in the treatment and discharge process in accordance with these protocols. 3. For every admission to a state hospital from the CSB's service area that currently is not served by that CSB, the CSB shall admit the person to the mental health program area, open case, and assign case management responsibilities to the appropriate staff**.** ***RECOMMENDED PRACTICE:*** For each admission, the CSB should make

	State Hospital Responsibilities	CSB Responsibilities
		every effort to establish a personal contact (face-to-face or by telephone or video communication) at least weekly for acute admissions and at least monthly for individuals receiving extended treatment.
1.5	The treatment team shall, to the greatest extent possible, accommodate the CSB when scheduling CTP and TPR meetings. Staff shall make every effort to inform the CSB of the date and time of the CTP meeting at least two business days prior to the scheduled meeting. ***NOTES:*** 1. The CTP meeting shall be held within seven business days of the date of admission. *2.* When practicable, special consideration shall be given to scheduling and discharging individuals admitted with a primary substance abuse diagnosis, with attention focused on diversion efforts and other community alternatives. ***RECOMMEDED PRACTICE:*** 1. State hospitals should develop and make available to CSBs centralized scheduling for all CTP and TPR meetings. This process may be automated to allow for the posting of an e-mail calendar that would also provide advance notice for all treatment planning meetings.	CSB staff shall make arrangements to attend or otherwise participate in CTP and TPR meetings. If CSB staff is unable to physically attend the CTP or TPR meeting, it is the CSB's responsibility to notify the state hospital social worker and request arrangements for telephone or video conferencing accommodations. In the event that this is not possible, it is the responsibility of the CSB staff to contact the treatment team or state hospital social worker within 24 business hours to discuss case specifics prior to receipt of the *Needs Upon Discharge Form.* ***NOTES:*** 1. While it may not be possible for the CSB to attend every treatment planning meeting, it is understood that attendance at treatment planning meetings is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. 2. A basic principle is that all individuals who are clinically ready for discharge shall, to the greatest extent possible, be seen face-to-face by CSB staff before they are discharged from the state hospital. 3. For individuals receiving extended treatment in a state hospital, CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual. 4. For individuals receiving acute care treatment in a state hospital, CSBs shall, to the greatest extent possible, ensure attendance at no less than one CTP or

	State Hospital Responsibilities	CSB Responsibilities
		TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has served the individual within the past 60 calendar days), the CSB has documented this determination in the individual's medical record and the CSB has had telephone or video conference communication with the individual and the treatment team that explains and discusses this determination.
1.6	State hospital staff, in collaboration with CSB staff, shall arrange for telephone and video conferencing accommodations for CSB staff and authorized representatives who are invited to attend meetings but are unable to attend in person.	

2. Needs Assessments and Discharge Planning

	State Hospital Responsibilities	CSB Responsibilities
2.1	The treatment team, in consultation with the CSB, shall ascertain, document, and address the preferences of the individual and his or her authorized representative in the needs assessment and discharge planning process that will promote the recovery, self-determination, empowerment, and community integration of the individual.	
2.2	The social worker shall complete a psychosocial assessment prior to the CTP for each individual. This assessment shall serve as one basis for determining the individual's needs upon discharge. The treatment team shall document the individual's preferences in assessing the needs upon discharge. Although the entire treatment team and CSB staff shall participate in evaluating the individual's needs, the social worker or his designee is responsible for documenting these needs on the *Needs Upon Discharge Form* section of the CTP. ***NOTE:*** 1. For individuals with a dual diagnosis who may be eligible for services under the Medicaid I.D. Waiver, the following shall be established: a. staff has conducted a current psychological assessment, and b. Medicaid eligibility has been determined and confirmed.	CSB staff shall initiate discharge planning upon the individual's admission to a state hospital. Discharge planning begins on the Initial Preadmission Screening form and continues on the *Discharge Plan Form (DBH 1190C)* section of the CTP. In completing the discharge plan, the CSB shall consult with the treatment team, the individual, the authorized representative, and, with the individual's consent, family members or other parties in determining his or her preferences upon discharge. The *Discharge Plan Form* shall indentify- • anticipated date of discharge from the state hospital, • services needed for successful community placement and the frequency of those services, and • public or private providers that have agreed to provide these services. ***NOTES:*** 1. For individuals with a dual diagnosis, CSB mental health and developmental services directors or their designees shall conduct case review and an assessment of the CTP to ensure intra-agency coordination. 2. For individuals with a dual diagnosis who may be eligible for services under the Medicaid I.D. Waiver, CSB staff shall establish eligibility and, as needed, placement on a waiting list. ***RECOMMENDED PRACTICE*:** For those individuals who are deaf, hard of hearing, late deafened, or deaf-blind, the CSB should coordinate its discharge planning effort with the regional deaf services coordinator.

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2.3	The *Needs Upon Discharge Form* shall be filled out as completely as possible by the social worker or his or her designee at the CTP meeting. If the CSB is unable to attend the CTP meeting, state hospital staff shall ensure that the *Needs Upon Discharge Form* is completed to the greatest extent possible in the secure site database within one business day of the CTP meeting.	CSBs shall, to the greatest extent possible, attend all CTP meetings. At the initial CTP meeting, CSB staff shall fill out as completely as possible the *Discharge Plan* section of the CTP. If CSB staff is unable to attend the meeting, they shall initiate the *Discharge Plan* in the secure site database within three business days of the initial CTP meeting or receipt of the *Needs Upon Discharge Form*. The *Discharge Plan Form* shall address each need identified on the *Needs Upon Discharge Form.*
2.4		The *Discharge Plan Form* shall not be filled out in the absence of the *Needs Upon Discharge Form.* If the *Needs Upon Discharge Form* is not available at the initial CTP meeting or within one business day, CSB staff shall notify the treatment team leader or the social worker. If the *Needs Upon Discharge Form* is not made available, upon notification of the problem, CSB staff shall notify the state hospital social work director.
2.5	The *Needs Upon Discharge Form* shall be initiated at the first CTP meeting and updated at subsequent TPR meetings. As an individual's needs change, the social worker shall document changes on the needs upon discharge section of the secure site database and in the social worker's progress notes. If the CSB is not present at the TPR meeting, state hospital staff shall update the *Needs Upon Discharge Form* in the secure site database within one working day of the TPR meeting and provide notification to the CSB of those updates.	The *Discharge Plan Form* shall be initiated at the first CTP meeting and updated at subsequent meetings. If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the *Discharge Plan Form* to address changes to the *Needs Upon Discharge Form.* If CSB staff is unable to attend the TPR meeting, they shall update the *Discharge Plan Form* in the secure site database within three business days of receipt of the revised *Needs Upon Discharge Form.* ***NOTE:*** Where applicable, CSB mental health, developmental, and substance abuse services staff shall work jointly in the

	State Hospital Responsibilities	CSB Responsibilities
		development and execution of the discharge plan.
2.6		As part of the individual's medical record, the CSB shall provide, at a minimum, discharge planning notes every 30 days. These notes shall be recorded by the CSB in the secure site database. ***NOTES:*** 1. A CSB presence at the state hospital is not required for the completion of discharge planning notes. Discharge planning notes are to be entered into the secure site database only.

3. Recovery and Individualized Treatment Planning

	State Hospital Responsibilities	CSB Responsibilities
3.1	The treatment team, in consultation with CSB staff, shall develop an individualized treatment plan that is designed to address admitting and presenting factors, the resolution of which will lead to discharge and enhance community tenure. The treatment team shall develop, with the input and recommendations of the individual, his or her authorized representative, and the CSB, goals that will indicate the end of the treatment phase at the state hospital. Goals identified shall develop strengths and reinforce the individual's hope for a meaningful life outside of the state hospital.	
3.2	The individual, his or her authorized representative, CSB staff, and, with the individual's consent, family members and private providers who will be involved in providing services shall be included in the treatment planning process and shall be asked to sign the treatment plan if present at treatment team meetings. The treatment team shall anticipate and assist the individual to develop a recovery plan and obtain a durable power of attorney, as deemed appropriate or necessary for successful community living.	
3.3	An individual's treatment plan shall address those skills and behaviors identified by the individual and the treatment team that promote hope, self-advocacy, and personal responsibility and facilitate education and the supports necessary for a satisfying and hopeful life outside of the state hospital.	
3.4	With the individual's consent, state hospital staff, in collaboration with CSB staff, shall attempt to notify family members by telephone, secure email, or letter of dates and times of treatment team meetings whenever possible.	

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3.5	The treatment team, in consultation with CSB staff, shall ascertain, document, and address the preferences of the individual and his or her authorized representative about the individual's placement upon discharge. The preferences of the individual and his or her authorized representative shall be addressed in good faith and to the greatest degree practicable in determining the optimal and appropriate discharge placement. ***NOTE:*** This may not be applicable for certain forensic admissions due to their legal status.	

4. Readiness for Discharge

	State Hospital Responsibilities	CSB Responsibilities
4.1	The treatment team, in consultation with CSB staff, shall determine that the individual is clinically ready for discharge and state hospital level of care is no longer required when: the individual achieves the treatment goals identified in his or her CTP; for voluntary admissions, when consent has been withdrawn; or for children or adolescents, when any of the following situations exists: • The minor is unlikely to benefit from further acute inpatient psychiatric treatment; • The minor has stabilized to the extent that inpatient psychiatric treatment in a state hospital is no longer the least restrictive treatment intervention; or • The legal guardian, if the minor is a voluntary admission, or the minor, if he is age 14 or older, has withdrawn consent for admission.	
4.2	Decisions regarding discharge readiness shall be made at scheduled, called, or ad hoc CTP or TPR meetings. To the greatest extent possible, CSB staff, the individual, and his or her authorized representative shall be a part of the decision making process in determining whether or not the individual is clinically ready for discharge. If the CSB staff has not participated in the CTP or TPR meeting when the individual was determined to be ready for discharge, the state hospital social worker shall communicate decisions about discharge readiness to the CSB staff. The state hospital social worker shall contact the CSB by telephone within one business day of the meeting and provide notification of readiness for discharge and document the call in the individual's medical record. This contact shall be followed by a written notification to the CSB. ***NOTES:*** 1. The state hospital social worker shall notify the social work director and forensic coordinator and the CSB of any individual receiving forensic services who has been identified by the treatment team as clinically and legally ready for discharge to a correctional center or facility. 2. When disagreements regarding readiness for discharge occur, the CSB and the treatment team shall make a reasonable effort to resolve the disagreement. If initially unresolved, a resolution effort shall be initiated to include at least one face-to-face meeting with state hospital and CSB staff at a level higher than the treatment team and written documentation of the meeting's contents shall be included in the individual's medical record. This meeting shall occur within 10 business days of the notification of discharge readiness.	
4.3		If the CSB agrees that the individual is ready for discharge, it shall take immediate steps to finalize the discharge plan within 10 calendar days. The individual shall be discharged from the state hospital as soon as possible but in no more than 30 calendar

	State Hospital Responsibilities	CSB Responsibilities
		days from the notification, except as provided for in Section 4.6 when the CSB experiences extraordinary barriers making it impossible to complete the discharge within 30 calendar days of notification. ***NOTES:*** 1. A basic principle is that all individuals who are clinically ready for discharge shall be seen face-to-face or via electronic audio and video communication by CSB staff before they are discharged from the state hospital. 2. For those individuals receiving extended treatment, the CSB shall ensure staff attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to discharge. 3. For those individuals receiving acute care treatment, the CSB shall ensure staff attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has served the individual within the past 60 calendar days) and has documented this determination in the individual's medical record, and the CSB has had telephone or video conference communication with the individual and the treatment team that explains and discusses this determination.
4.4	State hospital and CSB staff shall collaborate as needed in finalizing the discharge plan. ***NOTE***: It is the sole responsibility of the CSB to make the initial individual referral to all private providers, including nursing homes and assisted living facilities. The CSB may request that state hospital staff assist the referral process as needed following the initial contact.	

	State Hospital Responsibilities	CSB Responsibilities
	RECOMMENDED PRACTICE: For acute admissions, the CSB and treatment team shall accelerate the discharge process to shorten the time frames recommended and ensure continuity for existing community supports.	
4.5		After discharge, if the individual is not able to make the necessary decisions regarding treatment in the community and an authorized representative does not exist, the CSB executive director shall appoint one. ***RECOMMENDED PRACTICE*:** Whenever possible, an authorized representative needs to be in place by the date of discharge from the state hospital.
4.6		In the event the CSB experiences extraordinary barriers, including insufficiency of state funding or lack of community infrastructure, such as willing providers, making it impossible to complete the discharge within 30 calendar days of notification of clinical readiness, the CSB shall submit documentation in the secure site database about why the discharge cannot occur within 30 calendar days of notification. The completed *Extraordinary Barriers to Discharge Form (DBH 1192*) shall describe the barriers to discharge and the specific steps being taken by the CSB to address them. This documentation shall be submitted no later than 30 calendar days from the notification of readiness for discharge and shall be part of the individual's medical record. Monthly discharge planning notes shall be submitted until the extraordinary barriers have been addressed and the individual has been discharged.
4.7	State hospital and CSB staff shall review on a monthly basis those individual cases that have been determined to be impossible to discharge within 30 calendar days and document in the medical record and in the secure site database the CSB's progress in addressing barriers to ensure that discharges are occurring at reasonable pace. In addition, the CSB and state hospital regional utilization management structure shall review at least monthly the placement status of these individuals at the region's primary state hospital who have been determined to be ready for discharge. The Department's Assistant Commissioner for Behavioral Health Services or his designee shall monitor through the secure site database the progress in discharging these individuals with	

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	extraordinary barriers to discharge.	
4.8	If the CSB agrees that the individual is ready for discharge but has not yet completed the discharge plan, the treatment team leader or his designee shall notify the director of social work and the CSB staff responsible in writing of the problems and issues associated with the CSB's completion of the discharge plan.	If the CSB has determined that the individual is ready for discharge and the treatment team has not determined readiness for discharge, the CSB shall provide a completed *Discharge Plan Form* and a proposed discharge date to the treatment team. This documentation shall be part of the individual's medical record. In the event that the disagreement between the CSB and the treatment team remains unresolved, the procedures outlined in Section 4.2 shall be followed.
4.9		If the CSB disagrees that the individual is clinically ready for discharge and has notified the treatment team, the procedures outlined in Section 4.2 shall be followed.

5. Completing the Discharge Process

	State Hospital Responsibilities	CSB Responsibilities
5.1	State hospital staff, in collaboration with CSB staff, shall initiate applications for Medicaid, Medicare, SSI or SSDI, and other financial entitlements (e.g., indigent medications). Applications shall be initiated in a timely manner prior to actual discharge. For individuals receiving extended treatment, the application process shall begin not less than 30 days prior to the anticipated date of clinical readiness for discharge. Each team member and CSB staff are responsible for timely and comprehensive reports required for the applications. To facilitate follow-up, the state hospital social worker shall notify the CSB of the date and type of entitlement applications submitted. This also will be reflected in the *Needs Upon Discharge Form*.	
5.2	The treatment team shall prepare the *Discharge Information and Instructions Form* and obtain the physician's review and signature prior to discharge. At the actual time of discharge, state hospital staff shall review the *Discharge Information and Instructions Form* with the individual and his or her authorized representative and request the applicable signatures. Distribution of the *Discharge Information and Instructions Form* shall be provided to all next level of care providers no later than one business day after discharge. ***NOTE:*** Individual review of the *Discharge Information and Instructions Form* may not be applicable for certain forensic admissions due to their legal status. ***RECOMMENDED PRACTICE:*** A psychiatrist should evaluate the individual and document the evaluation in 24 hours or less before the time of discharge.	To reduce readmissions to state hospitals, CSBs shall develop and complete, as clinically determined, a *Safety and Support Plan* that is part of the individual's final discharge plan. ***NOTES:*** 1. *Safety and Support Plans* are usually not required for court ordered evaluations, restoration to competency cases, and jail transfers. However, at the clinical discretion of the treatment team or CSB, development of a specialized *Safety and Support Plan* may be advantageous when the individual presents significant risk factors or may be returning to the community after a brief incarceration in jail. 2. For individuals with a dual diagnosis, an individualized behavior management or a *Safety and Support Plan* shall be part of the discharge plan. 3. These plans must work in conjunction with any pre-existing dual diagnosis protocols developed between the state hospital and its service area and reflect any related regional protocol**.** 4. CSB staff shall ensure all arrangements for psychiatric services and medical follow-up appointments are in place prior to discharge. 5. CSB staff shall ensure coordination of any other intra-agency services, e.g., employment, outpatient, or residential.

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5.3	The medical director shall be responsible for ensuring that the *Discharge Summary* is provided to the CSB (and correctional facility when appropriate) to the greatest extent possible within 14 and no more than 30 calendar days of the actual discharge date.	
5.4		The CSB case manager, primary therapist, or other designated staff shall schedule an appointment to see the individual who has been discharged from a state hospital within seven business days of discharge or sooner if the individual's condition warrants an earlier appointment.
5.5		Individuals discharged from a state hospital who have missed their first appointment with the CSB case manager, primary therapist, psychiatrist, or day support program shall be contacted no later than 24 hours after the missed appointment. Written documentation shall be provided of efforts to see the person face-to-face no later than seven business days after the missed appointment. ***NOTE:*** Individuals discharged from a state hospital with continuing psychotropic medications needs shall, to the greatest extent practicable, be scheduled to be seen by a CSB psychiatrist within seven business days after discharge or sooner if the individual's condition warrants an earlier appointment. In no case shall this initial appointment be scheduled later than 14 business days after discharge.

6. Transfer of Case Management CSB Responsibilities

	State Hospital Responsibilities	CSB Responsibilities
6.1	The social worker shall indicate in the progress notes any intention that is clearly expressed by the individual or his or her authorized representative to change or transfer case management responsibilities to another CSB and the reason(s) for doing so. This shall be documented in the individual's medical record. Once staff receives the *Out of Catchment Referral Form*, state hospital staff shall schedule a discharge conference within five business days that will include both CSBs.	Transfer of case management responsibilities among CSBs shall occur when the individual receiving services or his or her authorized representative decides to relocate to another CSB service area. If a CSB pursues placement of an individual outside of its service area, the CSB shall notify the state hospital staff and the CSB affected by the potential transfer of case management responsibilities. This shall be documented in the CSB note section of the secure site database. The referring CSB must complete and forward to the treatment team and the receiving CSB a copy of the *Out of Catchment Referral Form* ***NOTE:*** Coordination of the possible transfer shall allow when possible for discussion of resource availability and resource allocation between the two CSBs prior to advancement of the transfer**.**
6.2	To the greatest extent possible, staff shall provide written notification to the current and new case management CSB at least two business days before the final TPR meeting. The treatment team shall, to the greatest extent possible, accommodate both CSBs when scheduling the final TPR meeting.	Case management services shall be provided by the new CSB promptly upon discharge unless otherwise specified. At a minimum, the new case management CSB shall attend the final TPR meeting prior to the actual discharge date. The CSB of origin is responsible for completing the *Discharge Plan, Conditional Release Plan, and Safety and Support Plan.* The CSB of origin shall stay involved with the individual and the placement and remain CSB of origin for no less than 30 calendar days after discharge. The receiving CSB also shall sign off on the *Discharge Plan* and be actively involved in the development of the *Safety and Support Plan*. Arrangements for and logistics of this involvement shall be documented in the *Discharge Plan Form, Safety and Support Plan Form, Monthly Discharge Note*s, and the

	State Hospital Responsibilities	CSB Responsibilities
		individual's medical record. The CSB of origin shall, upon notice of transfer, provide the new CSB with a copy of all relevant documentation related to the treatment of the individual. ***NOTE:*** The criteria delineated in this section also shall apply to all individuals with dual diagnoses regardless of vendor, Medicaid I.D. Waiver eligibility, or placement site.
6.3		If the two CSBs cannot agree on the transfer of case management responsibility within seven business days of notification of intent to transfer, they shall seek resolution from the Department's Assistant Commissioner for Behavioral Health Services. The CSB of origin shall initiate this contact.

7. Shelter and Temporary Placements

	State Hospital Responsibilities	CSB Responsibilities
7.1	If discharge to a shelter is clinically recommended and the individual has decision-making capacity and has expressed this preference, the treatment team social worker shall document this recommendation in appropriate sections of the *Needs Upon Discharge Form.* The treatment team social worker shall notify the director of social work when an individual expresses a preference to be discharged to a shelter and CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director or his or her designee. Following this review, the medical director or his or her designee shall document endorsement of the plan for discharge to a shelter in the interdisciplinary notes section of the individual's medical record.	For individuals with a primary diagnosis of mental illness or mental illness and intellectual disability, discharge to a shelter shall be part of the individual's discharge plan only if it is clinically recommended, optimal, and the individual's expressed preference or if continued hospitalization would be detrimental to the individual's clinical condition and all other residential possibilities have been exhausted.
7.2	The treatment team social worker shall notify the CSB within 24 hours of the recommendation that the individual be discharged to a shelter or other temporary placement.	The CSB shall update the *Discharge Plan Form* to reflect the individual's preference for discharge to a shelter, identifying on the form the comprehensive community supports that must accompany discharge to this temporary setting and documenting the CSB's plan to secure long-term stable housing for the individual.
7.3	If this recommendation is conveyed prior to the CTP meeting and discharge appears to be imminent prior to the CTP, the social worker shall document the preference and notify the CSB immediately.	If notification is given prior to the CTP meeting and the discharge may occur prior to that time, the CSB must agree to the placement and provide the social worker with details in the form of a discharge note as to how the CSB will provide support services and work toward securing long-term stable housing for the individual.
7.4	In the case of out of catchment area shelter placements, the CSB of origin and the receiving CSB shall be consulted and agree to the placement and service provision arrangements. The treatment team social worker shall provide both CSBs with notification as directed in section 7.1	The case management and receiving CSBs shall follow the same procedures as outlined in Section 6 for out-of-catchment area placements.

	State Hospital Responsibilities	CSB Responsibilities
7.5	If the identified placement is a homeless shelter, a hotel, or other temporary housing, the treatment team social worker shall document on page 3 of the *Discharge Information and Instruction Form* that this type of placement is not recommended or preferred by the treatment team and that it is the individual's preference. The social worker shall document that ongoing efforts are being made by the CSB to secure alternative and more permanent housing.	
7.6	The treatment team psychiatrist or his or her designee shall record a *Discharge Note* in the *Interdisciplinary Notes* section of the individual's medical record. If the identified placement is a homeless shelter, a hotel, or other temporary housing, the *Discharge Note* shall clearly indicate that this type of placement is not recommended, that it is the individual's preference, and that ongoing efforts are being made by the CSB to secure alternative and more long-term, stable housing.	